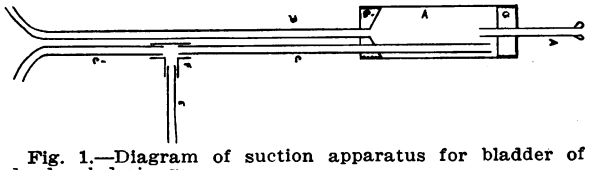

Fig. 1.—Diagram of suction apparatus for bladder of duodenal drainage.

A —Hollow brass wire $\frac{3}{8}$ inch outside diameter, 2 inches long.
B —Copper tubing ¼ inch outside diameter, 36 inches long.
C —Hollow brass wire $\frac{3}{8}$ inch outside diameter, 32 inches long.
C'—Copper tubing ¼ inch outside diameter, 10 inches long.
D —Brass tubing ¾ inch outside diameter, 6½ inches long.
E —Copper tubing ¼ inch outside diameter, 1½ inches long.
F —Brass "T."
G-G'—Brass plugs, threaded and shaped as shown in diagram.

The water dropping from *A* through *D* leaves by way of *B*, thus creating a partial vacuum in *D* and *C*, but the lower end of *C'* being submerged the suction is made manifest in *E*, which is connected to the site to be drained. Fluid entering *E* runs down the lower part of *C'* and does not go up into *D*.

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EPIDIDYMITIS—SOME CLINICAL OBSERVATIONS

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THERE are several valuable points of clinical interest to the general surgeon and clinician relative to acute and chronic inflammatory reactions within the epididymis. It would be only a reiteration of known knowledge to classify the several types and enumerate the usual textbook symptomatology; and my purpose, therefore, in this short paper is to draw attention to a few outstanding features relative to epididymal inflammations, trusting that they may be of some value in the office or at the bedside.

Clinical practice seems to reveal the fact that support, properly applied, is more important in promoting resolution of inflammatory conditions of the epididymis (non-tubercular) than any type of local application one may use. Smearing the scrotum with black, glycerinated concoctions promises little, except a black and messy dressing.

The following adhesive plaster dressing may be tried: Use an ordinary gauze flat, roll it (tightly) lengthwise like a cigar and run a strip of plaster, one-half inch wide, around and down the length of it, similar to the "barber pole" stripe. This will keep the gauze from unrolling. Tear off a strip of plaster, one inch wide and about eight inches long, and lay the gauze-roll lengthwise and in the center of the adhesive side of the strap. Lay the scrotum flat upon the abdomen and strap the gauze-roll in place, transversely across the perineum and behind the testicles, running the ends of the adhesive plaster up to either groin and thus forming a sling, behind which the testicles will not slip, as the gauze-roll acts as a barrier. Next, strap the scrotum and contents against the abdomen with two-inch adhesive, applied transversely. Do not worry about the dressing impeding the act of urination, as the patient will manage satisfactorily. Add new supports to this dressing as needed. Immediate cessation of pain and the ability to get around actively is the result that may be expected from this treatment.

Examine the cord frequently in cases of acute epididymitis. A "pipe stem" sensation imparted to the examining fingers points to funiculitis of the cord. It is best not to play tag with this condition. Open up the scrotum, free the fascia about the cord well up to the external ring, slit the epididymal sheath, drain freely with penrose through the lower end of the scrotum and sew up the original incision with black silk. Temporize with this condition and abscess of the testicle with resultant orchidectomy will be your penalty.

Persistence of marked epididymal swelling after ten days, pain and soreness failing to subside early, temperature persisting after five days—any or all of these signs in evidence means epididymal, and possibly testicular abscess, and diagnoses a surgical scrotum. Do not drain an acute eipdidymitis that reveals pus. Do an epididymectomy.

Always explain to the patient, preoperatively, that the testicle may be abscessed and a removal of the same may be necessary, so that your endeavor to do conservative surgery upon an epididymis, showing pus, will leave you a loophole through which you may sneak back later and do an orchidectomy, because ten chances to one that is precisely what you will have to do. Drainage of the acute epididymis by early multiple punctures may be all right, but if you find any pus in those needle holes, then remove the epididymis at once.

In dealing with epididymitis in the elderly individual, do a bilateral vasectomy. I believe that severing the vas, especially on the affected side, will break the continuity for absorption from the vesicle and prostatic area.

There are two points to bear in mind in doing scrotal surgery for tuberculosis. First, considering the frequency of tuberculosis in other parts of the body, in patients with scrotal tuberculosis you must prepare yourself to combat a rapid flare-up of some other tubercular rest following your scrotal surgery. As a popular cartoonist puts it: "They'll do it every time." Perhaps not every time, but sufficiently frequent to keep one busy enough. You may think that ligation of the vas, high up, and cauterization will prevent this distressing aftermath; but sad experience has taught me the fallacy of this theory. Such procedure is important and necessary, but do not be surprised if things happen to cause much concern later on.

The second point to which I wish, in conclusion, to call attention to is closure in scrotal surgery for tubercular conditions. Leave the scrotum wide open and pack with iodoform gauze. Expect a sinus, or perhaps two or maybe three; then, if your patient surprises you and heals without a sinus, you will be happily disappointed.

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